Evinacumab-dgnb (Evkeeza)

Provider Order Form rev. 10/20/2025

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

☐ E78.010 Homozygous familial hypercholesterolemia

THERAPY ADMINISTRATION

☑ Administer Evkeeza 15mg/kg _____ mg IV in 100ml to 250ml of 0.9%NS or D5W over 60 minutes every 4 weeks

ADDITIONAL ORDERS

LABORATORY ORDERS

☐ Monitor LDL-C levels ☐ every 2 weeks ☐ every 4 weeks
☐ Other: _____

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO
☐ Loratadine 10mg PO
☐ Pepcid 20mg ☐ PO / ☐ IVP
☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP
☐ Solumedrol ☐ 40mg / ☐ 125mg IVP
☐ Other: _____

NURSING

☑ Hold infusion and notify provider if there is a chance pt is pregnant.
☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation
☑ Record Vital signs prior to discharge

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications with statins and any other lipid lowering agent, allergies, cardiac history, History of CAD, MI, TIA, Stroke, or cardiac catheterization.

Required Labs: LDL, full lipid panel, and cholesterol levels

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.